Chapter 5

Claim Form Requirements

INTRODUCTION

Claims for services must be submitted to the AHCCCS Administration on the correct form for the type of service billed. This chapter outlines the requirements for completing the CMS 1500, UB-92 and ADA 2002 claim forms.

NOTE: This chapter applies to *paper* CMS 1500, UB-92, and ADA 2002 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

CMS 1500 REQUIREMENTS

The CMS 1500 claim form is used to bill for:

- ☑ IHS and 638 tribal claims for individual practitioner services
- ☑ Emergency and non-emergency transportation
- ☑ Durable medical equipment

The following general billing rules apply:

- ☑ CPT and HCPCS procedure codes must be used to identify all services.
- ☑ ICD-9 diagnosis codes are required.
  - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

COMPLETING THE CMS 1500 CLAIM FORM

The following instructions explain how to complete the CMS 1500 claim form and whether a field is "Required," "Required if applicable," or "Not required."

1. **Program Block** **Required**

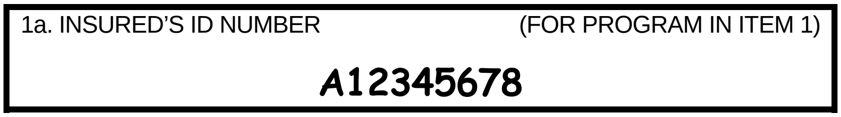
   Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(Medicare#)*	☒ *(Medicaid#)*	☐ *(Sponsor's SSN)*	☐ *(VA File #)*	☐ *(SSN or ID)*	☐ *(SSN)*	☐ *(ID)*

COMPLETING THE CMS 1500 CLAIM FORM

1a. Insured's ID Number **Required**

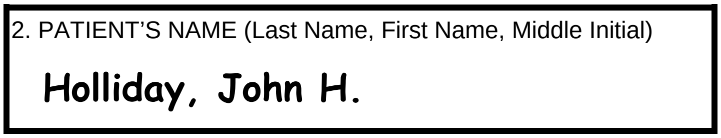
Enter the recipient's *AHCCCS ID number*. If you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Eligibility). Behavioral health providers must enter the client's AHCCCS ID number, *not* the client's BHS number.



1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)
A12345678

2. Patient's Name **Required**

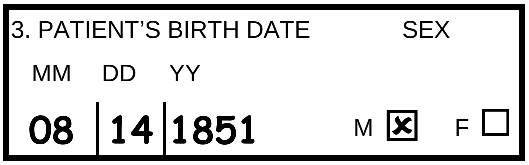
Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.



2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Holliday, John H.

3. Patient's Date of Birth and Sex **Required**

Enter the month, day, and year (MM/DD/YYYY format) of recipient's birth. Check the appropriate box to indicate the patient's gender.



3. PATIENT'S BIRTH DATE SEX
MM DD YY
08 | 14 | 1851 M ☒ F ☐

4. Insured's Name **Not required**

5. Patient Address **Not required**

6. Patient Relationship to Insured **Not required**

7. Insured's Address **Not required**

8. Patient Status **Not required**

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

9. Other Insured's Name **Required if applicable**

If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number **Required if applicable**

Enter the group number of the other insurance.

9b. Other Insured's Date of Birth and Sex **Required if applicable**

If the other insured is not the AHCCCS recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.

9c. Employer's Name or School Name **Required if applicable**

Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

9d. Insurance Plan Name or Program Name **Required if applicable**

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient's Condition Related to: **Required**

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)

☒ YES ☐ NO

b. AUTO ACCIDENT? PLACE (State)

☐ YES ☒ NO

c. OTHER ACCIDENT?

☐ YES ☒ NO

11. Insured's Group Policy or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

11b. Employer's Name or School Name **Required if applicable**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**

Check the appropriate box to indicate coverage other than AHCCCS. If “Yes” is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Not required**

13. Insured's or Authorized Person's Signature **Not required**

14. Date of Illness or Injury **Required if applicable**

Enter the appropriate date in MM/DD/YYYY format.

15. Date of Same or Similar Illness **Not required**

16. Dates Patient Unable to Work in Current Occupation **Not required**

17. Name of Referring Physician **Required if applicable**
17a. ID Number of Referring Physician

Required only for podiatry services.

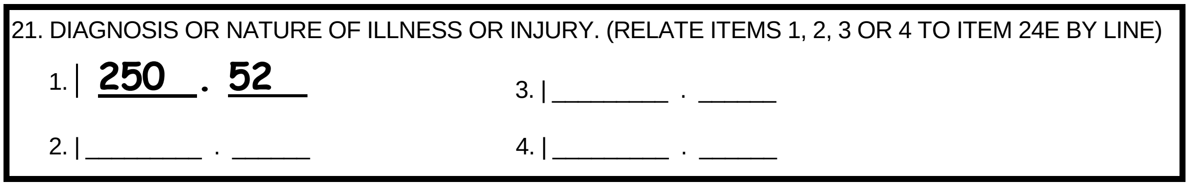
18. Hospitalization Dates Related to Current Services **Not required**

19. Reserved for Local Use **Not required**

20. Outside Lab **Not required**

21. Diagnosis Codes **Required**

You must enter at least one *ICD-9 diagnosis code* describing the recipient’s condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. You may enter up to four diagnosis codes in priority order (primary condition, secondary condition, etc.).



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. | 250 . 52 3. | ________ . ______

2. | ________ . ______ 4. | ________ . ______

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

22. Medicaid Resubmission Code **Required if applicable**

Enter the appropriate code (“A” or “V”) to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
A	040010004321

23. Prior Authorization Number **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 6, Authorizations/Referrals, for information on prior authorization.

24A. Date of Service **Required**

Enter the beginning and ending service dates in MM/DD/YY or MM/DD/YYYY format. If the service was completed in one day, the dates will be the same. The “To” date must be equal to or prior to the billing date (Field 31).

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From			To						
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
02	15	04	02	30	04				

or

02	15	2004	02	30	2004				

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

03	School
04	Homeless shelter
05	IHS Free-standing Facility
06	IHS Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	ER - Hospital
24	ASC
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	FQHC
51	Inpatient Psych Facility
52	Psych Facility - Partial Hospitalization
53	Community Mental Health Center
54	ICF/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psych Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	ESRD Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

24. A						B	C	D	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From			To						
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
						05			

24C. Type of Service **Not required**

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24D. Procedure and Procedure Modifier **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment. If more than two modifiers are required to completely delineate the service provided, enter "99" as the first modifier, then list the modifiers being billed with the procedure code. Call Claims Customer Service to verify that a modifier is valid for a procedure code.

24. A						B	C	D		
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER	
								71010	26	

24E. Diagnosis **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

D			E	F		G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan
CPT/HCPCS	MODIFIER						
			1				
			1, 2				

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24F. Charges **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150 00		
			79 00		

24G. Units **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
				2	
				1	

24H. EPSDT/Family Planning **Not required**

24I. Emergency **Required if applicable**

Mark this box with a "✓," an "X," or a "Y" if the service was an emergency service, regardless of where it was provided.

E	F	G	H	I	J	K
DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
				✓		

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

24J. COB **Required if applicable**

Check this box for coordination of benefits if there is Medicare or other insurance coverage for the services billed on this line.

E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
					✓	

24K. Reserved for Local Use **Required if applicable**

Use this field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient's Deductible has been met, enter zero (Ø) for the Deductible amount.

For recipients and services covered by any other third party payer, enter only the amount *paid*.

Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24K. Leaving the field blank will cause the claim to be denied.

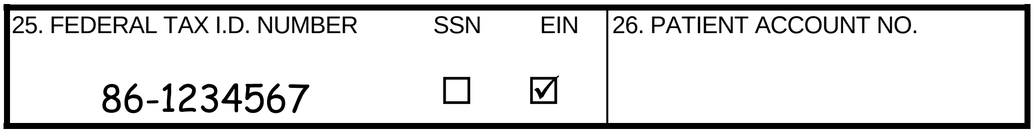
See Chapter 7, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance.

E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
						175 / 0

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

25. Federal Tax ID **Required**

Enter your tax ID number and check the box labeled "EIN." If you do not have a tax ID, enter your Social Security Number and check the box labeled "SSN."



25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	☐	☑	

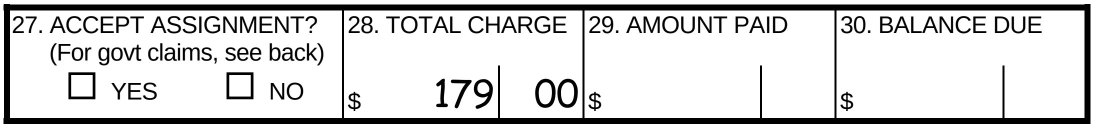
26. Patient Account Number **Required if applicable**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.

27. Accept Assignment **Not required**

28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.



27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☐ YES ☐ NO	$ 179 00	$	$

29. Amount Paid **Required if applicable**

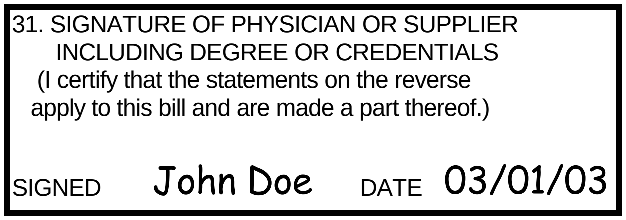
Enter the total amount that you have been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. Balance Due **Not required**

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

31. Signature and Date **Required**

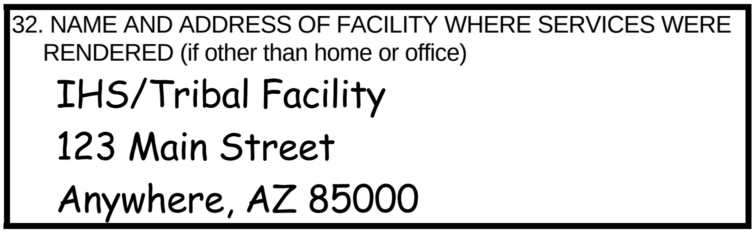
The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.



31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREE OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED John Doe DATE 03/01/03

32. Name & Address of Facility Where Services Were Rendered **Required if applicable**



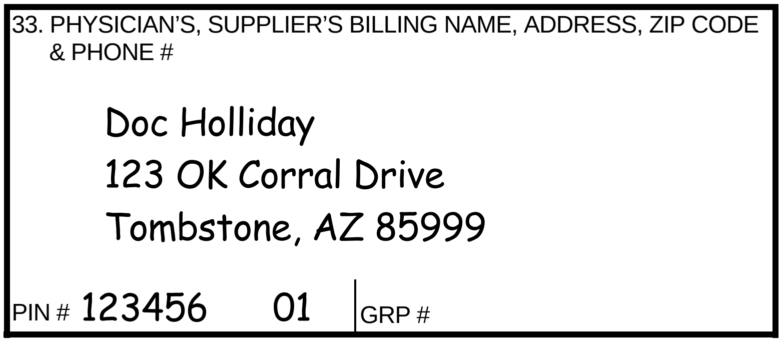
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE
RENDERED (if other than home or office)

IHS/Tribal Facility
123 Main Street
Anywhere, AZ 85000

33. Provider Name, Address and Phone **Required**

Enter your provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

Enter the *service* provider's six-digit *AHCCCS provider ID number* and *two-digit locator code* next to "PIN #." Do not enter more than two digits for locator code. Behavioral health providers must **not** enter their BHS provider ID number.



33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
& PHONE #

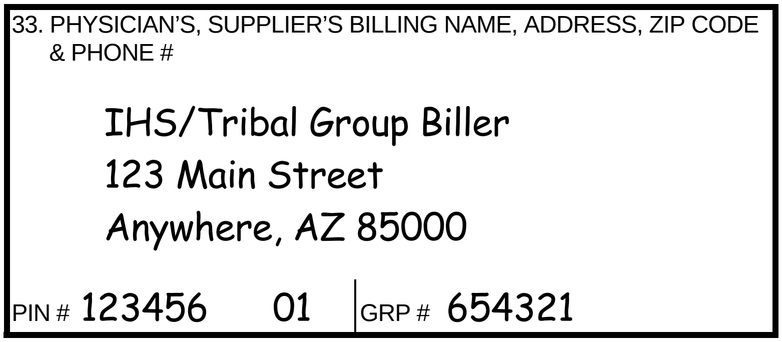
Doc Holliday
123 OK Corral Drive
Tombstone, AZ 85999

PIN # 123456 01 GRP #

COMPLETING THE CMS 1500 CLAIM FORM (CONT.)

33. Provider Name, Address and Phone (Cont.) **Required**

If a group is billing, enter the *service* provider's six-digit *AHCCCS provider ID number* and *two-digit locator code* next to "PIN #." Enter the *group biller ID* in the "GRP#" field.



33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

IHS/Tribal Group Biller
123 Main Street
Anywhere, AZ 85000

PIN # 123456 01 | GRP # 654321

UB-92 REQUIREMENTS

The UB-92 claim form is used to bill for:

☑ All IHS and 638 tribal facility inpatient and outpatient claims for Title XIX (Medicaid) and Title XXI (KidsCare) recipients

☑ Nursing facility services

☑ Residential treatment center services

☑ Dialysis facility services

The following general billing rules apply:

☑ Revenue codes are used to bill line-item services provided in a facility.

☑ Revenue codes must be valid for the service provided.

☑ ICD-9 diagnosis codes are required.

  ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

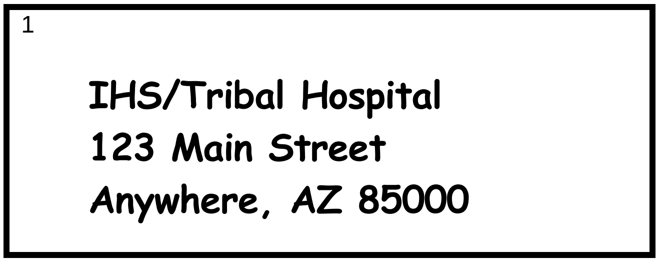
☑ ICD-9 procedure codes must be used to identify surgical procedures billed on the UB-92.

COMPLETING THE UB-92 CLAIM FORM

The following instructions explain how to complete the UB-92 claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-92*.

1. **Provider Data** **Required**

Enter the name, address, and phone number of the provider rendering service.



1

IHS/Tribal Hospital
123 Main Street
Anywhere, AZ 85000

2. **Unassigned** **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

3. Patient Control No. **Required if applicable**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and your own accounting or tracking system.

4. Bill Type **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See *UB-92 Manual* for codes.

2.	3. PATIENT CONTROL NO.	4. TYPE OF BILL
		111

5. Fed Tax No. **Required**

Enter your facility's federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD		7. COV D
	FROM	THROUGH	
86-1234567			

6. Statement Covers Period **Required**

Enter the beginning and ending dates of the billing period in MM/DD/YY or MM/DD/YYYY format.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD		7. COV D
	FROM	THROUGH	
	02/15/04	02/20/04	

or

	02/15/2004	02/20/2004	

7. Covered Days **Not required**

8. Non-covered Days **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

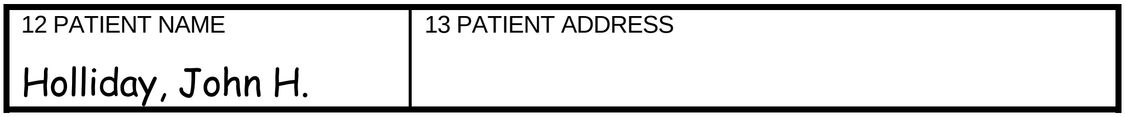
9. Coinsurance Days **Not required**

10. Lifetime Reserve Days **Not required**

11. Group Provider ID **Not required**

12. Patient Name **Required**

Enter the recipient's last name, first name, and middle initial as they appear on the AHCCCS ID card.

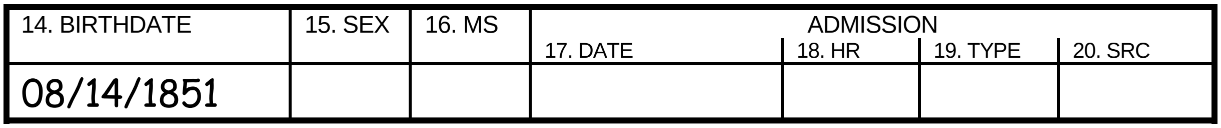


12 PATIENT NAME	13 PATIENT ADDRESS
Holliday, John H.	

13. Patient Address **Not required**

14. Patient Birth Date **Required**

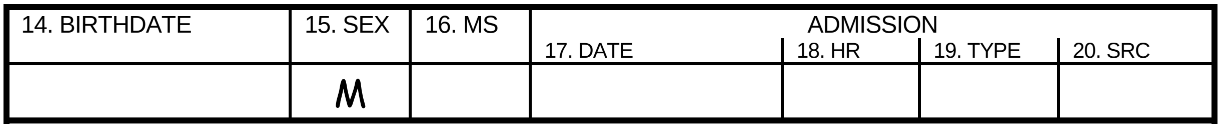
Enter the month, day, and year (MM/DD/YYYY format) of recipient's birth.



14. BIRTHDATE	15. SEX	16. MS	ADMISSION			
			17. DATE	18. HR	19. TYPE	20. SRC
08/14/1851						

15. Sex **Required**

Enter “M” (male) or “F” (female).



14. BIRTHDATE	15. SEX	16. MS	ADMISSION			
			17. DATE	18. HR	19. TYPE	20. SRC
	M					

16. Marital Status **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

17. Admission Date **Required**

Enter the admission date in MM/DD/YY or MM/DD/YYYY format.

14. BIRTHDATE	15. SEX	16. MS	ADMISSION			
			17. DATE	18. HR	19. TYPE	20. SRC
			02/15/04			

or

			02/15/2004			

18. Admission Hour **Required if applicable**

Enter the code which best indicates recipient's time of admission. Required for inpatient claims. See *UB-92 Manual* for hour codes.

14. BIRTHDATE	15. SEX	16. MS	ADMISSION			
			17. DATE	18. HR	19. TYPE	20. SRC
				19		

19. Admit Type **Required if applicable**

Required for all inpatient claims. An Admit Type of "1" is required for emergency inpatient and outpatient claims.

1 Emergency: Patient requires medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.

2 Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.

3 Elective: Patient's condition permits time to schedule services.

4 Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.

COMPLETING THE UB-92 CLAIM FORM (CONT.)

20. Admit Source **Required if applicable**

Required for all inpatient claims. Enter the code that describes the admission source:

Adults and Pediatrics:

1 Physician referral
2 Clinic referral
3 HMO referral
4 Transfer from hospital
5 Transfer from skilled nursing facility
6 Transfer from another health care facility
7 Emergency room
8 Court/Law enforcement
9 Information not available

Newborns: (Refer to Field 19)

1 Normal delivery
2 Premature delivery
3 Sick newborn
4 Extramural birth

21. Discharge Hour **Required if applicable**

Enter the code which best indicates the recipient's time of discharge. Required for inpatient claims when the recipient has been discharged. See *UB-92 Manual* for codes.

COMPLETING THE UB-92 CLAIM FORM (CONT.)

22. Patient Status **Required if applicable**

Required for all inpatient claims. Enter the code that best describes the recipient's status for this billing period.

01	Discharged to home or self-care
02	Transferred to another short term general hospital
03	Discharge/Transferred to SNF
04	Discharge/Transferred to ICF
05	Discharge/Transferred to another type of institution
06	Discharge/Transferred to home under care of home health service organization
07	Left against medical advice
08	Discharge/Transferred to home IV provider
09	Admitted as an inpatient to this hospital
20	Expired or did not recover
30	Still a patient
40	Expired at home (hospice only)
41	Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice
42	Expired, place unknown (hospice only)
50	Hospice - home
51	Hospice - medical facility
61	Discharge/Transferred within this institution to Medicare-approved swing bed
62	Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation unit of a hospital
63	Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)
64	Discharge/Transferred to a nursing facility certified under Medicaid but not certified under Medicare
71	Discharge/Transferred/Referred to another institution for outpatient services
72	Discharge/Transferred/Referred to this institution for outpatient services

23. Medical Record No. **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

24.–
30. Condition Code **Required if applicable**

Enter the appropriate condition codes that apply to this bill. See *UB-92 Manual* for codes.

31. Unassigned **Not required**

32.–
35
(a-b) Occurrence Codes and Dates **Not required**

36.
(a–b) Occurrence Span Code and Dates **Not required**

37. Internal Control Number **Not required**

38. Responsible Party Name and Address **Not required**

39.
41. Value Codes and Amounts **Required if applicable**

Enter the appropriate code(s) and amount(s). See *UB-92 Manual* for codes. The following codes are required on claims with Medicare or other insurance.

A1	Medicare Part A Deductible	A2	Medicare Part A Coinsurance
B1	Medicare Part B Deductible	B2	Medicare Part B Coinsurance
C1	Third Party Payer Deductible	C2	Third Party Payer Coinsurance

The following codes are required on dialysis claims from free-standing and hospital-based dialysis facilities when billing for administration of Erythropoietin (EPO):

49	Hematocrit test results	68	EPO units administered

COMPLETING THE UB-92 CLAIM FORM (CONT.)

42. Revenue Code **Required**

Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-92 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	132		
2	251		
3	258		
4			

43. Revenue Code Description **Required**

Enter the description of the revenue code billed in Field 42. See *UB-92 Manual* for description of revenue codes.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1		OB/3&4 BED	
2		DRUGS/GENERIC	
3		IV SOLUTIONS	
4			

44. HCPCS/Rates **Required if applicable**

Enter the inpatient (hospital or nursing facility) accommodation rate. For outpatient surgery performed in an ASC or the outpatient department of a hospital, enter the CPT code for the surgical procedure when billing for outpatient surgery for Title XIX (Medicaid) recipients (See Chapter 9, Facility Services).

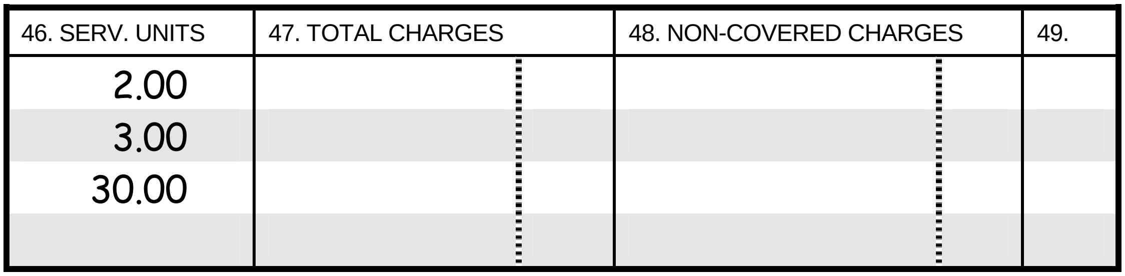
	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1			1,088.00
2			85595
3			95900
4			

COMPLETING THE UB-92 CLAIM FORM (CONT.)

45. Service Date **Not required**

46. Service Units **Required**

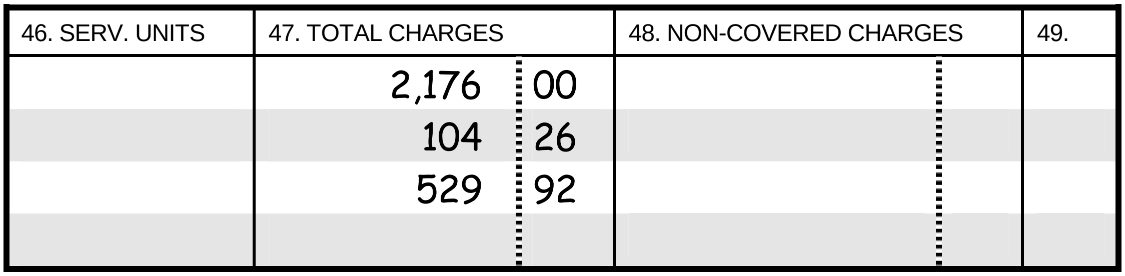
If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.



46. SERV. UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
2.00					
3.00					
30.00					

47. Total Charges By Revenue Code **Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.



46. SERV. UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
	2,176	00			
	104	26			
	529	92			

48. Non-covered Charges **Required if applicable**

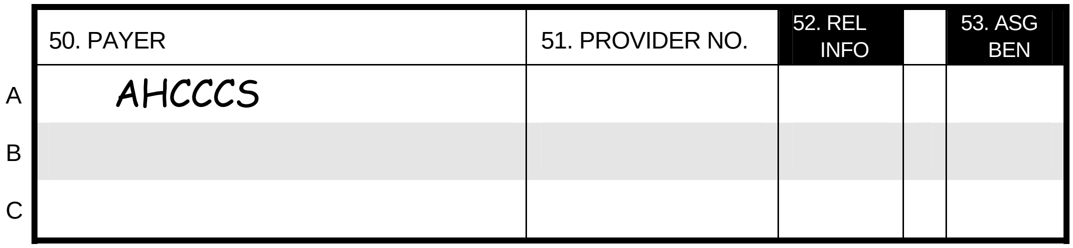
Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

49. Unassigned **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

50.
(A–C) Payer **Required**

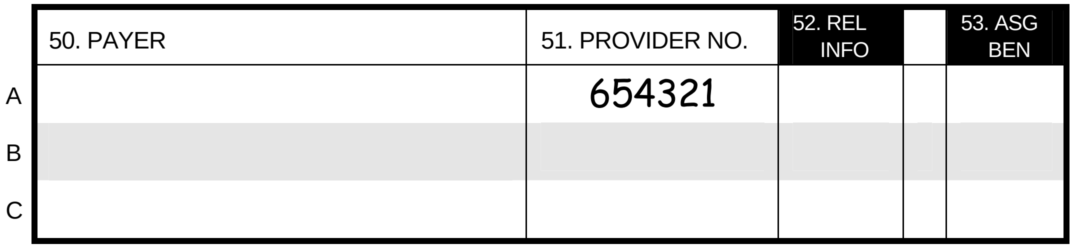
Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.



	50. PAYER	51. PROVIDER NO.	52. REL INFO		53. ASG BEN
A	AHCCCS				
B					
C					

51.
(A–C) Provider No. **Required**

Enter your facility's ID number as assigned to you by the payer(s) listed in Fields 50 A, B, and/or C. Your six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.



	50. PAYER	51. PROVIDER NO.	52. REL INFO		53. ASG BEN
A		654321			
B					
C					

52.
(A–C) Release of Information **Not required**

53.
(A–C) Assignment of Benefits **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

54.
(A–C) Prior Payments **Required if applicable**

Enter the amount received from Medicare Part B or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter “Ø.” The "Ø" indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

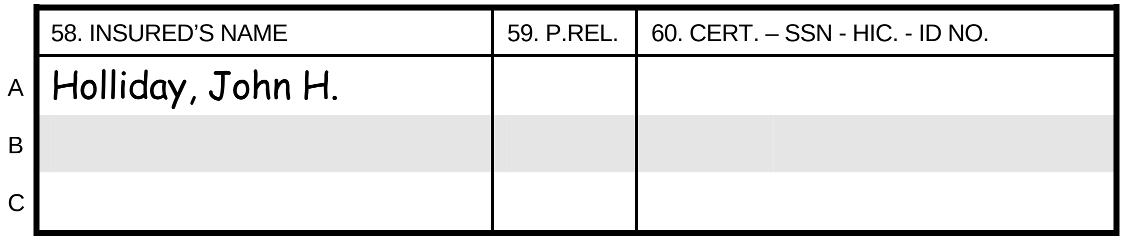
55.
(A–C) Amount due **Not required**

56. Unassigned **Not required**

57. Unassigned **Not required**

58.
(A–C) Insured's Name **Required**

Enter the name of insured (AHCCCS recipient) covered by the payer(s) in Field 50.



	58. INSURED’S NAME	59. P.REL.	60. CERT. – SSN - HIC. - ID NO.
A	Holliday, John H.		
B			
C			

59.
(A–C) Patient's Relationship To Insured **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

60.
(A–C) Patient CERT. - SSN – HIC – ID NO. **Required**

Enter the recipient's AHCCCS ID number. If you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Eligibility). Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

	58. INSURED'S NAME	59. P.REL.	60. CERT. –SSN - HIC. - ID NO.
A			A12345678
B			
C			

61.
(A–C) Group Name **Required**

Enter "FFS."

60. CERT. –SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.
	FFS	

62.
(A–C) Insurance Group Number **Not required**

63.
(A–C) Treatment Authorization **Not required**

64.
(A–C) Employment Status Code **Not required**

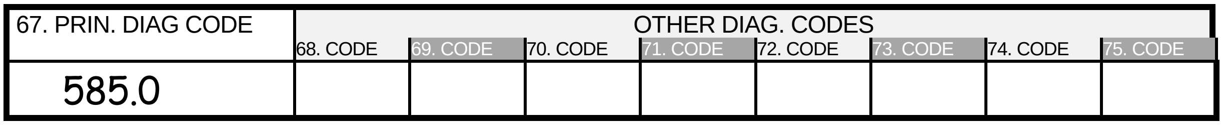
65.
(A–C) Employer Name **Not required**

COMPLETING THE UB-92 CLAIM FORM (CONT.)

66.
(A–C) Employer Name **Not required**

67. Principal Diagnosis **Required**

Enter the principal *ICD-9 diagnosis code*. Behavioral health providers must **not** use DSM-4 diagnosis codes.



67. PRIN. DIAG CODE	OTHER DIAG. CODES							
	68. CODE	69. CODE	70. CODE	71. CODE	72. CODE	73. CODE	74. CODE	75. CODE
585.0								

68. –
75. Other Diagnosis **Required if applicable**

Enter other applicable ICD-9 diagnosis codes. Include codes for other conditions that existed during the episode of care but were not primarily responsible for admission.

76. Admitting Diagnosis **Required if applicable**

Required for inpatient bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.

77. E-Codes **Required if applicable**

Enter trauma diagnosis code, if applicable.

78. DRG **Not required**

79. Procedure Method **Not required**

80. Principal Procedure Code and Dates **Required if applicable**

Enter the principal ICD-9 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

COMPLETING THE UB-92 CLAIM FORM (CONT.)

81. Other Procedure Codes **Required if applicable**

Enter other procedure codes in descending order of importance.

82. Attending Physician **Not required**

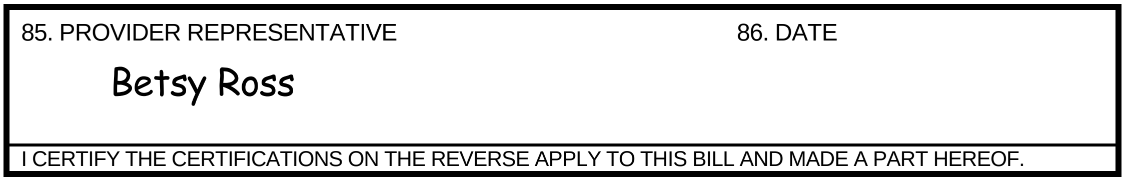
83. Other Physician **Not required**

84. Remarks **Required if applicable**

Required on resubmissions, adjustments, and voids. Enter the CRN of the claim being resubmitted, adjusted, or voided. For resubmissions of denied claims, write "Resubmission" in this field.

85. Provider Representative **Required**

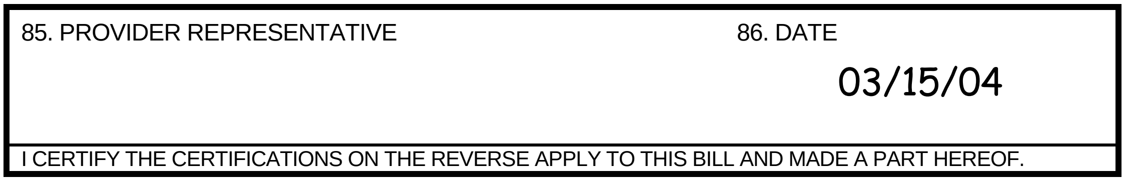
An authorized representative must sign each claim form verifying the certification statement on reverse of claim. Rubber stamp or facsimile signatures are acceptable but must be initialed by a provider representative.



85. PROVIDER REPRESENTATIVE
Betsy Ross
86. DATE
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND MADE A PART HEREOF.

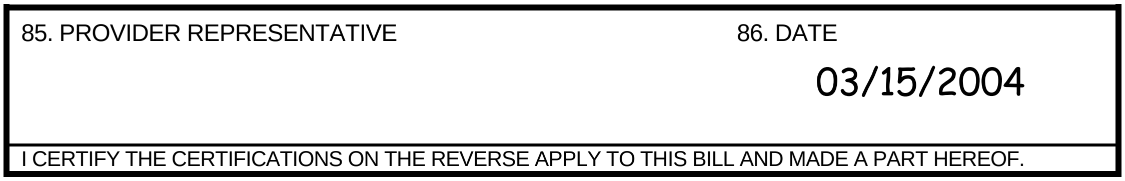
86. Date **Required**

Enter the date the claim is submitted in MM/DD/YY or MM/DD/YYYY format.



85. PROVIDER REPRESENTATIVE
86. DATE
03/15/04
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND MADE A PART HEREOF.

or



85. PROVIDER REPRESENTATIVE
86. DATE
03/15/2004
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND MADE A PART HEREOF.

ADA 2002 CLAIM FORM

IHS and 638 tribal dental claims for title XXI (KidsCare) recipients for dates of service on and after January 1, 2004 must be billed on the ADA 2002 form. Claims billed on a CMS 1500 claim form for dates of service on and after January 1, 2004 will be denied.

COMPLETING THE ADA 2002 CLAIM FORM

The following instructions explain how to complete the ADA 2002 Claim Form and whether a field is "Required," "Required if applicable," or "Not required."

1. **Type of Transaction** **Not required**

2. **Predetermination/Preauthorization Number** **Required if applicable**

   Enter the appropriate code ("A" or "V") to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided.

See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

2. Predetermination/Preauthorization Number

040010004321

3. **Primary Payer Name and Address** **Required if applicable**

4. **Other Dental or Medical Coverage** **Required**

   Check appropriate box to indicate whether recipient has third party coverage.

4. Other Dental or Medical Coverage? ☒ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. **Subscriber Name** **Required if applicable**

6. **Date of Birth** **Required if applicable**

7. **Gender** **Required if applicable**

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

8. Subscriber Identifier **Required if applicable**

9. Plan/Group Number **Required if applicable**

10. Relationship to Primary Subscriber **Required if applicable**

11. Other Carrier Name, Address **Required if applicable**

12. Primary Subscriber Name and Address **Required**

Enter recipient's last name, first name, and middle initial as shown on the AHCCCS ID card. Enter the recipient’s address

12. NAME (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Earp, Wyatt H.
123 E. OK Corral Drive
Tombstone, AZ 85638

13. Date of Birth **Required**

Enter the recipient’s date of birth.

13. Date of Birth

08/14/1851

14. Gender **Required**

Check the appropriate box to indicate the patient’s gender.

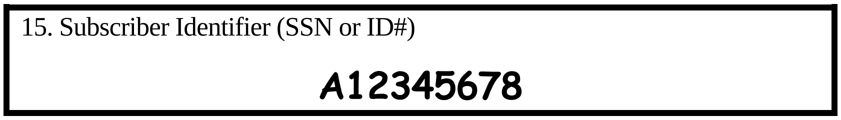
14. Gender

M ☒ F ☐

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

15. Subscriber Identifier **Required**

Enter the recipient's *AHCCCS ID number*. Contact the AHCCCS Verification Unit if there are questions about eligibility or the AHCCCS ID number. (See Chapter 2, Eligibility).



15. Subscriber Identifier (SSN or ID#)

A12345678

16. Plan/Group Number **Not required**

17 Employer Name **Not required**

18. Relationship to Primary Subscriber **Not required**

19. Student Status **Not required**

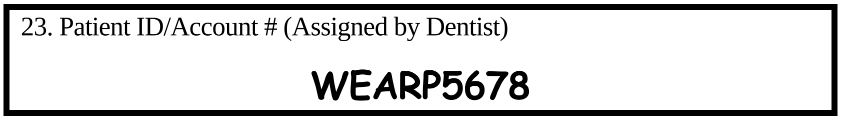
20. Name **Not required**

21. Date of Birth **Not required**

22. Gender **Not required**

23. Patient ID/Account Number **Required**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.



23. Patient ID/Account # (Assigned by Dentist)

WEARP5678

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

24. Procedure Date **Required**

Enter the procedure date in MM/DD/YYYY format.

24. Procedure Date (MM/DD/YYYY)		25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

25. Area of Oral Cavity **Required**

Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.

24. Procedure Date (MM/DD/YYYY)		25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

26. Tooth System **Required**

Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.

24. Procedure Date (MM/DD/YYYY)		25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

27. Tooth Number(s) or Letter(s) Required

Enter the tooth number when the procedure directly involves a tooth. Use commas to separate individual tooth numbers. If a range of teeth is involved, use a hyphen to separate the first and last tooth in the range.

24. Procedure Date (MM/DD/YYYY)		25. Area Of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1				
2				
3				

28. Tooth Surface Required

Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee		

29. Procedure Code Required

Enter the appropriate procedure code from the *CDT-4 Manual*.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee		

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

30. Description **Required**

Enter the description of the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee		

31. Fee **Required**

Enter the fee for the procedure code billed in Field 29.

28. Tooth Surface	29. Procedure Code	30. Description	31. Fee		

32. Other Fees **Not required**

33. Total Fee **Required**

Enter the total of all fees in Field 31.

32. Other Fee(s)			
33. Total Fee			

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

34. Missing Teeth **Required**

Mark all missing teeth.

MISSING TEETH INFORMATION	Permanent															
34. (Place an ‘X’ on each missing tooth)	1	2	X	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	22	26	25	24	23	22	21	20	19	18	17

35. Remarks **Not required**

36. Parent/Guardian Signature and Date **Not required**

37. Subscriber Signature and Date **Not required**

38. Place of Treatment **Required**

Check the appropriate box.

38. Place of Treatment (Check applicable box)
☒ Provider’s Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures **Required if applicable**

40. Is Treatment for Orthodontics? **Required**

Check the appropriate box. If “Yes” is checked, complete Fields 41 and 42.

40. Is Treatment for Orthodontics?
☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

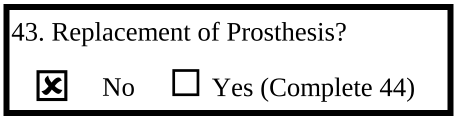
41. Date Appliance Placed **Required if applicable**

42. Months of Treatment Remaining **Required if applicable**

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

43. Replacement of Prosthesis **Required**

Check the appropriate box. If “Yes” is checked, complete Field 44.


43. Replacement of Prosthesis?
☒ No ☐ Yes (Complete 44)

44. Date of Prior Placement **Required if applicable**

If “Yes” is checked in Field 43, enter the date of prior placement in MM/DD/YYYY format.

45. Treatment Resulting From **Required if applicable**

Check the appropriate box, as applicable.

46. Date of Accident **Required if applicable**

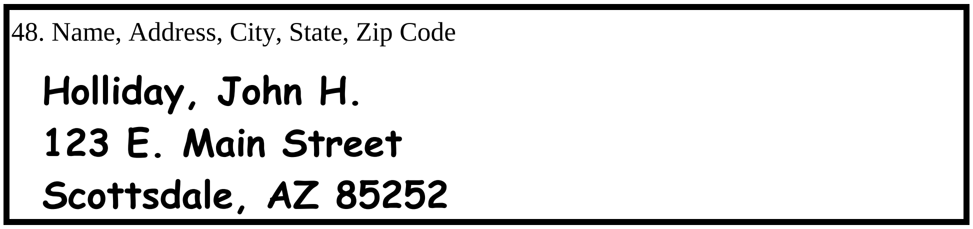
Enter the date in MM/DD/YYYY format.

47. Auto Accident State **Required if applicable**

Enter the name of the state where the accident occurred.

48. Billing Dentist/Dental Entity Name and Address **Required**

Enter the name and address of the billing dentist or dental entity.


48. Name, Address, City, State, Zip Code

Holliday, John H.
123 E. Main Street
Scottsdale, AZ 85252

49. Provider ID (Group) **Required**

Enter the AHCCCS provider ID of the billing dentist or dental entity.

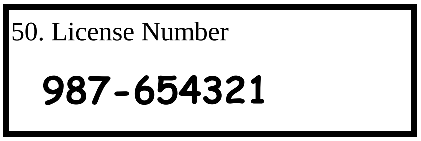
49. Provider ID

654321

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

50. License Number **Required**

Enter the license number of the billing dentist or dental entity.

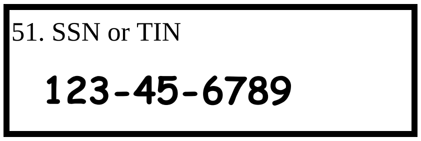


50. License Number

987-654321

51. SSN or TIN **Required**

Enter the Social Security Number or tax ID number of the billing dentist or dental entity.



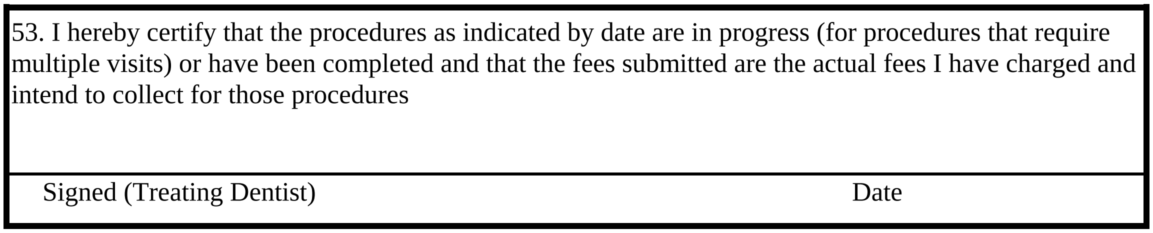
51. SSN or TIN

123-45-6789

52. Phone Number **Not required**

53. Signature of Treating Dentist **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.



53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures

Signed (Treating Dentist) Date

54. Provider ID **Required**

Enter the AHCCCS provider ID of the treating dentist.

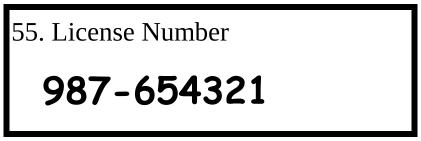
54. Provider ID

654321

COMPLETING THE ADA 2002 CLAIM FORM (CONT.)

55. License Number **Required**

Enter the license number of the treating dentist.



55. License Number

987-654321

56. Address (Treating Dentist) **Not required**

57. Phone Number (Treating Dentist) **Not required**

58. Treating Provider Specialty **Not required**